BUILDING AN INTEGRATED COMMUNITY RESPONSE TO CHILDREN WHO WITNESS VIOLENCE

CAMBRIDGE, MA

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EXECUTIVE SUMMARY

Through the Domestic Violence Free Zone (DVFZ) initiative, Cambridge has developed a unique approach to family violence prevention and intervention. Local government and community based organizations have provided support and guidance for the initiative, with representatives from major city departments as the primary conduits for developing and implementing DVFZ recommendations. With increased attention at the state and national level about the adverse impact on children of witnessing violence, the DVFZ initiative has prioritized the need to assess and develop services for children who witness violence.

The goal of this study is to assist the DVFZ Core Group with the development of an integrated, coordinated model for responding to children who witness violence. The goal of such a collaborative model is to ensure early identification of and intervention with children who witness violence.

Key Findings

This study included four primary components: a review of "best practices" in community based responses to children who witness violence; an analysis of existing Cambridge data related to children who witness violence; a survey of one hundred and five (n=105) Cambridge providers about their experiences and perceptions in working with children who witness violence; and a series of focus groups and interviews with additional providers. Key findings include:

- **Providers report that they regularly confront issues related to violence in their daily work with children.** Over 60% of providers report that they work with children *at least once a week* who have witnessed violence. In addition, almost 90% of providers report that children who witness violence have academic difficulties.
- **Cambridge has minimal data about the actual number of children who witness family violence.** Police records from 1993-1995 indicate that children are reported present at *23%* of

domestic violence calls. There is evidence to suggest that this figure is a significant underestimate of the number of children actually present at these calls.

- **Providers, especially teachers, emphasize the need for additional training on how to identify and respond to children who witness violence.** The level and type of training vary by provider type: less than 25% of school personnel report that they have had training related to working with children who witness violence, compared to 63% of providers overall.
- **There is limited collaboration between departments and agencies that serve children who witness violence.** In responding to children who witness violence, about one-third of providers indicated that they make referrals to professionals outside their own organizations or agencies. In addition, the shelter community has been underutilized as consultants to providers in need of expertise.
- **Providers report concerns about the role of the Massachusetts Department of Social Services (DSS) in responding to children who witness violence.** Reporting rates to DSS vary significantly by provider type. Of those providers who report that they have responded to children affected by violence, 38% of school personnel and child care workers refer to DSS, compared to 64% of providers overall.

Recommendations

In the beginning stages of this study, one of the possible policy options was to assist Cambridge to develop a strategic plan for a clinically-based program for children who witness violence. However, research findings suggest that before Cambridge implements additional clinical interventions, several critical steps must be taken to ensure a more integrated and holistic response to this population. In particular, survey findings underline the need for training and support for providers to strengthen their role in identifying and intervening with children who witness violence.

The table on the following page summarizes the key recommendations which have emerged from the research and preliminary work conducted. Based on an analysis of "model" community based practices in responding to children who witness violence, these recommendations are offered as a guide for the city's continued work.

BUILDING A COMMUNITY RESPONSE TO CHILDREN WHO WITNESS VIOLENCE: KEY RECOMMENDATIONS	
Early Identification and Intervention	• Implement DVFZ School Leadership Team training proposal for 1998-99. • Conduct an intensive, interdisciplinary training with the Child Witness to Violence Project for Cambridge providers. • Improve documentation of children's exposure to violence, specifically by the police, school, health, and human services departments.
Collaboration Between Departments and Agencies	• Enhance utilization of children's services programs at Transition House and Respond.
Partnership with Department of Social Services (DSS)	• Conduct in-service trainings between DSS and major city departments and agencies.
Services for Children Who Witness Violence	• Develop short-term working group to initiate further research, clarify need for additional therapeutic services, and pursue funding options.

A few of the above recommendations are de-centralized. In other words, these are recommendations that departments and agencies can undertake directly with DSS, in collaboration with other agencies, or in-house. There are also several recommendations that require more formal collaboration. In addition to working with the school & hospital based DVFZ task forces, the DVFZ Core Group should facilitate two time-limited working groups to implement the proposed collaborative recommendations.

The DVFZ initiative has provided an important foundation on which to build an integrated, community response to children who witness violence. Providers are encouraged to work with the VPC and the DVFZ Core Group to assess, refine and implement the proposed recommendations.

Conclusion

Cambridge has the resources and potential to develop a comprehensive, coordinated model for responding to children who witness violence. With the support of the City Manager and the collaborative efforts of city departments and community based organizations, the DVFZ initiative has provided a critical foundation for building the city's response to children who witness violence. It will take further research, collaboration, and commitment to successfully develop and implement this comprehensive model.

INTRODUCTION

Background: Cambridge's Domestic Violence Free Zone Initiative

In 1993, the Health Policy Board in Cambridge identified violence as the city's primary public health priority. Since that time, the city has taken several critical steps to address the problem of family violence. In 1994, the City Council declared Cambridge a "Domestic Violence Free Zone" (DVFZ) and directed all municipal and city-affiliated organizations to work collaboratively to reduce the incidence of family violence. DVFZ signs were posted throughout Cambridge with written and media information also disseminated. In addition, the city hired a Violence Prevention Coordinator to facilitate collaborative, city wide violence prevention efforts.

In April 1997, a city wide task force authorized by City Manager Bob Healy completed a *DVFZ Implementation Report* after a seven month planning process. The report outlines a collaborative, multidisciplinary plan to reduce the incidence of family violence in Cambridge over the next five years. The report identifies eleven key initiatives under four categorical areas: training; policies and protocols; education and outreach, and direct services [See Appendix A].

One of the primary areas of concern identified by the task force was the need to assess and develop services for children who witness family violence. Specifically, the *DVFZ Implementation Report* calls for the "development of therapeutic and support program(s) for children who witness family violence." The goal of this initiative is to identify children who witness family violence and to reduce the risk that children who witness will become perpetrators and/or victims of violence. The primary departments and agencies listed as key players in this initiative include the Cambridge Health Alliance (including Psychiatry, Pediatrics, and Neighborhood Health Centers), the School Department, the Police Department, and domestic violence non-profits. Task force members identified a one to five year time line of implementation for the initiative.

A smaller DVFZ Core Group, appointed by the City Manager after the report's submission, is responsible for overseeing the implementation of the initiatives outlined in the *DVFZ Implementation Report*. Richard Wright, the city's Violence Prevention Coordinator, is the Chair of the DVFZ Core

Group. Since November 1997, Mr. Wright has also facilitated an informal city wide working group to discuss the city's continued work in developing services for children who witness violence.

Structure of the PAE

The goal of this Policy Analysis Exercise (PAE) is to assist the DVFZ Core Group in developing a collaborative and integrated response to the needs of children who witness violence.

Primary Research Question:

- *Given the DVFZ initiative currently underway in Cambridge, how can the city develop a coordinated, comprehensive model for responding to children who witness violence?*

Related Research Questions:

- What are the components of a community based model for responding to children who witness violence?
- How do Cambridge providers currently identify and respond to children who witness violence?
- What types of supports do providers need to assist them in working with children who witness violence?

The rationale for municipal leadership in developing services for children who witness violence relates to the unique vision and overall structure of the DVFZ initiative: the role of *local government* in responding to family violence. Local government has provided political leadership for the initiative, and representatives from major city departments have been the primary agents in developing and implementing DVFZ recommendations. A "municipal" response to children who witness violence necessarily shares many of the same goals and components of model community based approaches; the important distinction rests with the explicit role played by local government.

In order to assist Cambridge in developing an integrated, municipal response to children who witness violence, I have organized this PAE into six major sections:

- **Children Who Witness Violence: Assessing the Nature and Magnitude of the Problem:** This section briefly reviews the literature concerning the impact on children of witnessing violence and assesses existing Cambridge data about the number of children exposed to violence.
- **Best Practices: Community Based Models for Responding to Children Who Witness Violence:** This section identifies four components of model community based approaches: early identification of children who witness violence; collaboration between departments and agencies;

partnerships with child protection agencies, and provision of comprehensive, integrated services for children and families.

- **Presentation of Key Findings:** This section focuses primarily on key findings which emerged from the provider survey, focus groups, and interviews. Findings are presented in two sub-sections: providers' perceptions about the magnitude and nature of the problem and an assessment of how Cambridge compares to the "best practices" model.
- **Recommendations: Toward an Integrated Model for Responding to Children who Witness Violence:** Using the "best practices" model as benchmark criteria, key recommendations are presented for the city to consider in its planning process.
- **Developing an Action Plan:** Given the existing resources and strengths of Cambridge's DVFZ initiative, specific action steps are outlined to facilitate implementation of recommendations.

Methodology

Assessment of Best Practices:

Components of community based models for responding to children who witness violence were identified through a review of the literature, interviews with experts in domestic violence, and discussions at related meetings and conferences, including a regional conference on children who witness violence sponsored by the Attorney General's Office and the Child Witness to Violence Project at Boston Medical Center.

Analysis of Existing Cambridge Data:

In order to assess the need for services for children exposed to violence, it is important to describe, both quantitatively and qualitatively, the population of children who witness family violence in Cambridge. Existing data from the Massachusetts Department of Social Services, the Cambridge Police Department, and the Cambridge School Health Surveys provide an important, but limited, starting point for examining current gaps in services for children who witness violence in Cambridge.

Provider Survey:

Given the limitations of existing data sources, a survey instrument was developed to elicit providers' input about the needs of children who witness violence [See Appendices B and C]. Designed to capture a wide range of provider perspectives, the survey was targeted toward professionals across the city who work directly with children in a variety of settings and have differing

levels of experience and training related to violence. The survey was developed after a review of the literature related to the impact of domestic violence on children; subsequent revisions ensured that questions were appropriate for an interdisciplinary range of providers who have varying levels of involvement with this issue.[1]

The goal of the survey was to assess provider *perceptions* about the following primary areas:

- **Prevalence of children who have witnessed violence**
- **Types of violence witnessed by children**
- **Identification of children who witness violence**
- **Needs of children who witness violence**
- **Current interventions with children who witness violence**
- **Need for additional resources**

It is important to emphasize that the survey is not a random sample of Cambridge providers who work with children. Instead, the distribution plan identified a *representative* sample of providers who work with children in different capacities; the goal of the plan was to elicit as wide a range of provider perspectives as possible. The survey provided an opportunity for providers to describe their experiences working with children affected by violence, including an assessment of their own capacity to identify and respond to these children.

Focus groups and interviews:

Focus groups and individual interviews were also conducted with a smaller number of providers [See Appendix D]. The goal of the focus group process was to elicit more detailed feedback from select groups of providers about particular issues. Questions from the provider survey were used to guide these discussions.

CHILDREN WHO WITNESS VIOLENCE:
Assessing the Nature and Magnitude of the Problem

Silent Victims: The Impact on Children of Witnessing Violence[2]

Understanding how witnessing violence affects children provides a critical starting point in the evaluation and development of appropriate services for children in Cambridge. Studies related to the impact on children of witnessing violence represent a relatively new area of interest and research. The literature reflects a growing consensus that children who witness violence are at risk for a range of adverse outcomes.[3] In addition, research suggests that between 68% and 87% of domestic violence incidents are witnessed by children, even though mothers often attempt to protect their children from domestic violence.[4] Three key findings from the literature are highlighted below.

Children who witness violence are themselves at risk for abuse

In the past, research about the impact of domestic violence on adult and child victims has followed separate lines of inquiry. However, recent research and practice have called critical attention to the relationship between battering and child abuse and the need to integrate domestic violence and child welfare services.[5] Other studies estimate that children are abused in 60% -75% of families where the mother is battered.[6]

Children who witness violence are at risk for adverse developmental, behavioral, and emotional outcomes

Recent research indicates that children who witness violence exhibit a wide range of adverse behavioral, psychological, and emotional outcomes. Studies also suggest that outcomes depend on a range of factors: the level and type of exposure to violence, the child's age, the victim's relationship to the child, and the presence of a parent or other caretaker to mediate the effects on the child.[7] Children who witness domestic violence are at risk for several adverse outcomes: developmental delays; psychological damage; acceptance of violence as a means of stress management and conflict resolution, and symptoms of post traumatic stress disorder.[8] Symptoms of post traumatic stress disorder include:

- **Numbing of responsiveness to the outside world** (constricted emotions, reduced play, withdrawn behavior, dissociative states, foreshortened view of the future);
- **Intrusive recollections of the traumatic incident** (flashbacks, reenactment through play, avoidance of traumatic cues, difficulties concentrating), and
- **Autonomic disturbances** (hyperarousal, hyperalertness, sleep disturbances, distractibility).[9]

Children who witness family violence may also experience a wide range of emotional problems, including feelings of shame, fear, anxiety, or guilt; the exposure to violence may also impair children's ability to trust or to form social relationships.[10]

Children who witness violence are more likely to become victims or perpetrators of violence

Research suggests that children who witness violence are more likely to perpetrate violence in their adult relationships and parenting experiences. For example, one study found that men who witnessed their fathers abuse their mothers were *three times* more likely to abuse their own wives than men who had not witnessed abuse as children (35% vs. 11%).[11] Another important study found only *one* variable to be strongly associated with men's future abuse of their female partners: having witnessed violence between their parents as children.[12] The majority of studies on batterers confirm that a high percentage of abusive men grew up in homes marked by abuse of a spouse, a child, or both.[13] Clearly, these findings do not mean that the majority of boys who witness violence become perpetrators as adults; nor do they suggest that all adult perpetrators of violence witnessed parental violence as children. Instead, these preliminary findings simply call important attention to the *risk* factors associated with witnessing violence as children.

Assessing the Magnitude of the Problem: Existing Data

In order to determine the need for services for children exposed to violence, it is important to assess what we know about the number of children who witness family violence in Cambridge. As in

most metropolitan areas, Cambridge has minimal data about the number of children who witness family violence. City departments and agencies that work with children often lack a clear protocol regarding the reporting of, or intervention with, children who witness violence but are not themselves victims of abuse. Although police data provide a primary source of information regarding the prevalence of domestic violence in the city, research suggests that between 60% and 80% of domestic assaults are never reported to the police.[14]

Existing data from the Massachusetts Department of Social Services, the Cambridge Police Department, and Cambridge School Health Surveys provide an important, but limited, starting point for examining current gaps in services. The following chart summarizes the key findings of existing data sources:

Table I: Cambridge Data Sources

DEPARTMENT	KEY DATA FINDINGS
Cambridge Police Department	• Children are reported present at 23% of domestic calls. Evidence suggests that this figure is a significant underestimate of the number of children actually present at these calls. • In 1996 and 1997, an estimated 300 children were involved in Cambridge related restraining orders.
Cambridge School Health Surveys	• About 10% of students in the Cambridge Middle Grades Health Survey reported that they had witnessed family violence within the previous 12 months. • About 9% of students in the Cambridge Teen Health Survey reported that they had witnessed family violence within the previous 12 months.
MA Department of Social Services (DSS)	• Children of domestic violence comprise *almost 70%* of all neglected and abused children statewide who come to the attention of DSS.[15]

Detailed information about these data sources can be found in Appendix E. It is important to point out that these figures tell us more about the frequency of the *reporting* of domestic incidents than their actual occurrence. In effect, existing data provides a very limited starting point for estimating the number of children who witness violence in Cambridge.

BEST PRACTICES:
Community Based Models for Responding to Children Who Witness Violence

Within the last few years, the issue of children who witness violence has gained increasing attention at both the state and national level; in addition, regional and local initiatives provide an important source of expertise and practice. Massachusetts is home to the Child Witness to Violence Project (CWVP) at Boston Medical Center, a nationally recognized model of clinical intervention with children exposed to violence [See Appendix F]. Founded in 1992, the Child Witness to Violence Project provides counseling, advocacy, and support for children and their families who have been affected by violence; program staff also provide consultation and training to other providers who work with young children who witness violence.

In order to assist Cambridge in developing an integrated, coordinated response to children who witness violence, it is important to consider not only model clinical interventions, but model community based approaches to family violence prevention and intervention. Although Cambridge appears to be unique in the explicit role asked of municipal government to reducing family violence, "best practices" in community based approaches to family violence also provide a useful road map for the city's efforts. In effect, coordinated responses to children who witness violence must emphasize the relationships between community based organizations, shelters, survivors, affected children and state and local government.

Components of community based models for responding to children who witness violence include:

Components of Community Based Models for Responding to Children who Witness Violence

- Early identification of and intervention with children who witness violence
- Collaboration between departments and agencies
- Partnerships with child protection agencies
- Integrated services for children and families affected by violence

One primary source of the "best practices" presented below is the 1996 Report of the Governor's Commission on Domestic Violence, *The Children of Domestic Violence*. Developed with

the input of researchers, clinicians, and service providers with expertise in serving children exposed to violence, the report's recommendations are based on one primary principle: the importance of developing "integrated community networks" to break the cycle of family violence.[16] Calling attention to the need for coordinated local and state responses to children affected by family violence, the report outlines effective benchmarks with which to assess Cambridge's progress.

In addition, community based responses to children who witness violence should be tied to broader child protection efforts; model programs and practices in child abuse prevention and intervention provide important lessons in this regard. In particular, a recent report by The Executive Session on Child Protection at the John F. Kennedy School of Government at Harvard University, *Child Protection: Building Community Partnerships*, provides useful benchmark for developing "community partnerships" for children which extend public responsibility for child safety.[17]

Early Identification and Intervention

Early identification of children who witness violence is the first step in responding holistically and effectively to children's needs. Model community based networks prioritize the development and implementation of trainings, educational programs, policies, and protocols which strengthen providers' ability to identify children and families affected by violence. Early identification of children who witness violence ensures that children have access to appropriate therapeutic and support services.

- **Role of Police.** Police officers play a critical role in the identification of and intervention with children who witness violence. The Community Based Policing Project, a collaboration between the New Haven Police Department and Yale University's Child Studies Center, represents one programmatic model; this model has also been replicated in several communities across the country, including Framingham, Massachusetts. Police officers are trained to understand the impact of violence on children, to evaluate a crime scene for harm to children, and to talk to children at the

scene of a crime. Officers are also able to seek 24-hour consultation services from mental health clinicians at the Center and to make follow up visits to children and their families. In effect, by prioritizing children's psychological well-being, the collaboration has fundamentally shifted the law enforcement community's response to children exposed to violence.[18] Similarly, the CWVP provides training for the Boston Police Department to strengthen officers' ability to respond to children at domestic violence calls and to facilitate "case finding": the identification of children at crime scenes who may be in need of therapeutic services.[19]

- **Ongoing Training and Education for Providers.** Identifying children who do not come to the attention of the police department is more problematic. The literature indicates that identifying children who are not themselves victims of abuse can be extremely difficult. Discipline specific training and education are critical if providers are to identify and respond to children who witness violence. Providers who work with children in health care, school, and social services settings need training related to the impact on children of witnessing violence. Providers also need training to be able to identify key behavioral or emotional characteristics associated with witnessing violence. For clinicians in primary care and mental health settings, early identification of children also requires clear protocol about screening and evaluating children for their exposure to violence. In addition, collaborative and interdisciplinary training initiatives provide an excellent forum to build relationships between providers.

Collaboration Between Departments and Agencies

Holistic, integrated community networks for children who witness violence are characterized by close and effective collaboration across agency and organizational lines.[20] Child and adult victims of violence should be able to access appropriate and comprehensive support services, regardless of their "entry point" into the system.[21] An integrated community network which supports multiple entry points

for children and families depends on effective community collaboration. Unfortunately, in many communities, the level and type of services available to children are limited by the lack of collaboration between departments and agencies. As *The Children of Domestic Violence* report emphasizes, "Under our present system, a child and his mother might receive emergency shelter services but no extended mental health care; legal assistance but no emergency shelter services; shelter and mental health services but no legal advocacy; or shelter services but no income support assistance."[22]

Research suggests that primary stakeholders in developing integrated community networks for children and families affected by violence include schools, day care centers, hospitals, police, domestic violence service providers, courts, child protection agencies, family support agencies, substance abuse prevention and treatment providers, and economic/welfare services.[23]

Partnerships with Child Protection Agencies

Model community based responses to children who witness violence must make *safety* for children *and* adult victims a key priority. Establishing effective partnerships with child protection agencies is a critical first step in this process.

Recent research and practice have emphasized the relationship between child abuse and domestic violence; however, historical and philosophical tensions between the child welfare and battered women's communities have often prevented collaborative efforts to protect *both* women and children.[24] Programs serving battered women and their children have often worked in isolation from one another and viewed each other with suspicion. The response of the child protection system was often to remove children from homes affected by domestic violence without addressing the needs of the battered mother.

Recently, model initiatives have called attention to the importance of enlisting child protection agencies as collaborative partners in developing integrated services for children and women affected by violence. In 1993, the Massachusetts Department of Social Services (DSS) created a Domestic Violence Unit in order to address the link between child abuse and domestic violence and to strengthen collaboration among service providers. The first public child welfare agency in the country to prioritize domestic violence in its clinical operations, DSS has taken some important steps toward integrating

services for battered women and their children. The unit includes domestic violence specialists who work with regional offices throughout the state.

Goals of DSS Domestic Violence Unit

- Provide support to families affected by violence;
- Avoid unnecessary foster care placement;
- Keep non-offending parents and their children safe and together;
- Collaborate with other agencies and community service providers to coordinate services for children and families;
- Train staff to identify domestic violence;
- Develop model pilot projects in local area offices which coordinate interagency teams; and
- Clarify protocols to improve investigation, assessment, and service planning.

Regionally and nationally, other pilot models of interagency collaboration with child protection agencies have recently been developed. These initiatives underscore the important link between child abuse and domestic violence and the importance of protecting children by protecting mothers.[25] For example, the Massachusetts Coalition of Battered Women's Service Groups (MCBWSG) recently piloted Project Safe Family: an interagency pilot collaboration between the public child protection system and domestic violence service providers. Project Safe Family aims to strengthen collaboration among battered women's programs, child protection agencies, and mental health agencies serving women and children.

Piloted first in Framingham in 1996, the Project Safe Family was designed to identify barriers to collaboration between domestic violence service programs and child welfare organizations through interagency focus groups and trainings.[26] The goals of these focus groups and trainings are to identify perceived barriers, build trust, and create opportunities for collaboration among providers. Currently, the Project Director at MCBWSG is reviewing focus groups results, developing protocol for real collaboration among involved agencies, and assessing the possibility of statewide replication at other sites.

Goals of Project Safe Family

- Every child protection worker recognizes domestic violence and uses intervention strategies and practices that help mothers find safety with their children;
- Every battered women's shelter offers mothers appropriate parenting support and provides specific services for her children; and
- Every family service agency - mental health, schools, hospitals and others - recognizes the link between domestic violence and child abuse and the impact of domestic violence on women and children, and offers appropriate services.[27]

Similarly, *Child Protection: Building Community Partnerships* effectively outlines a new role for child protection agencies: from being the sole provider of all child protective services to providing leadership in the development of community partnerships for child protection and neighborhood based systems of service delivery.[28]

Integrated Services for Children and Families Affected by Violence

Model community based approaches to serving children who witness violence should include the provision of comprehensive, integrated services for children and families. Once the child's situation has been assessed and evaluated, services for children and families may include individual therapy or group counseling for the child and mother, parenting programs, or advocacy services.[29]

Violence prevention and intervention services must also be linked to a community's broader commitment to improving the overall well-being of children and families.[30] Community based approaches to violence prevention and intervention must be integrated into wider efforts to address poverty, substance abuse, parental stress and isolation, and poor children's health and academic indicators.[31]

Finally, it is important to point out that the provision of comprehensive, integrated services for children and families represents more of a long range goal for communities. In addition, the extent to which communities are able to develop new services will depend in large part on new funding opportunities available at the state level.

PRESENTATION OF KEY FINDINGS

This section focuses primarily on key findings which emerged from the provider survey, focus groups, and interviews. One hundred and five (n=105) surveys were completed and returned. The majority of survey respondents (n=57, or 55%) were affiliated with the Cambridge Health Alliance. The following chart provides a summary breakdown of survey respondents by major city department or agency and provider affiliation:

Table II: Survey Respondents by Major City Department or Agency and Provider Affiliation

MAJOR CITY DEPARTMENT/AGENCY	%	PROVIDER AFFILIATION
Cambridge Health Alliance	55%	Child and adolescent psychiatry (including inpatient, outpatient, and emergency room); East Cambridge Health Center; Windsor St. Health Center; Victims of Violence Program; school nurses; pediatrics; Somerville Hospital Adolescent Inpatient Program and Ambulatory Care Social Services
Cambridge Public Schools	22%	King Open School; Kennedy School; Dr. MLK Jr. School; Peabody School; Cambridge Rindge and Latin High School
The Guidance Center	9%	Mental health teams
Department of Human Services	9%	Haggerty Preschool; Longfellow Preschool; MLK Preschool; School-age child care programs (Graham and Parks; Maynard)
Community Based Organizations	5%	Peabody Terrace Children's Center; Our Place Child Care Center, The Salvation Army

n = 105

It is important to point out that although the majority of survey respondents were affiliated with the Cambridge Health Alliance, these providers represent a wide range of roles and functions within the Alliance, as illustrated by their departmental or program affiliations.

PROVIDERS' PERCEPTIONS: NATURE AND MAGNITUDE OF THE PROBLEM

> ***It seems that there are so many children I know or have heard of who have witnessed violence in the school I teach in (CRLS). It is sometimes overwhelming to me to try and figure out what is the best way to approach the child's situation. I struggle with it all of the time. I feel that my impact is such a small one compared to the response that is needed in order to effectively help young adults who witnessed such events.***
>
> **- Special Needs Teacher, Cambridge Rindge and Latin High School**

Overall, providers report that they regularly confront issues related to violence in their daily work with children. In addition to reporting high estimated prevalence levels of children who witness violence in their caseloads, classrooms, and programs, providers concur that children who witness violence display a range of emotional, behavioral, and academic problems.

The following table summarizes key findings related to estimated prevalence; types of violence witnessed by children; identification of children who witness violence; and needs of children exposed to violence.

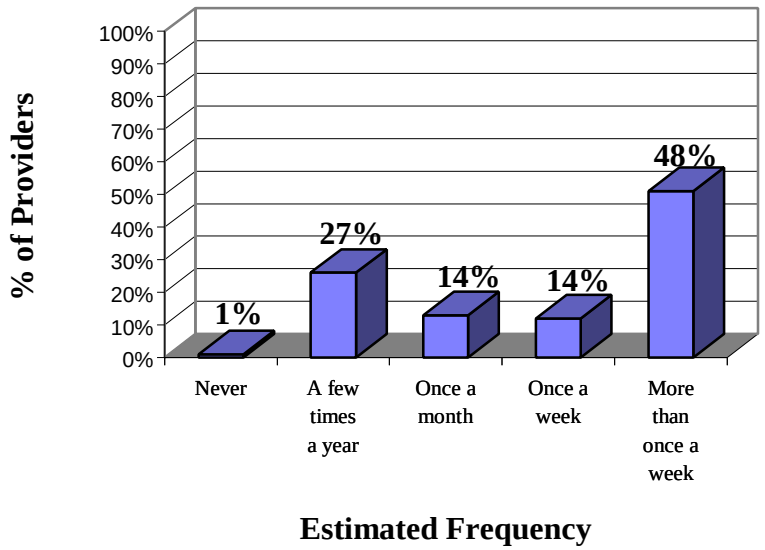
Table III: Providers Perceptions about Children Who Witness Violence

SURVEY QUESTION	KEY FINDING
Estimated Prevalence	• 62% of providers report that they work with children *at least once a week* who have witnessed violence.
Types of Violence	• 81% of providers perceive that family violence is the primary type of violence witnessed by children.
Identification of Children	• 77% of providers indicate that children disclose they have witnessed violence.
Needs of Children	• 89% of providers report that children who witness violence have academic difficulties.

Estimated prevalence

Survey respondents report that they are continually confronted with the issue of children exposed to violence, especially family violence. As one social worker at a neighborhood health center emphasized, "The amount of domestic violence is horrifying." The following graph summarizes the frequency with which providers work with children who have witnessed violence in their current professional roles.

***In your professional role, how often do you see or work with children who witness violence*?**



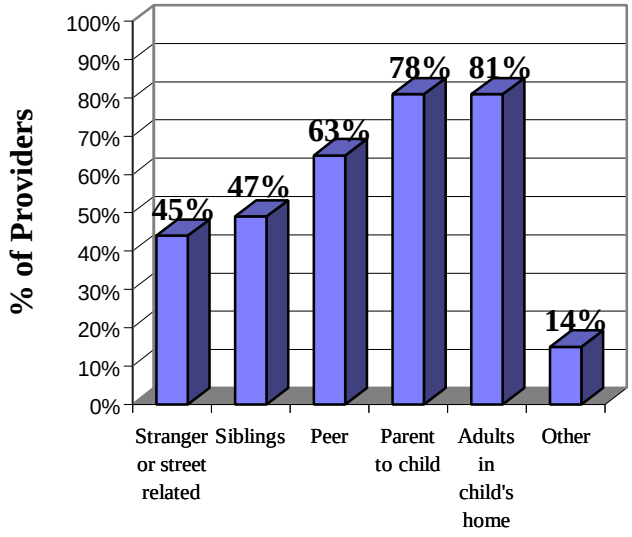
This graph indicates that 99% of survey respondents work, in some capacity, with children affected by violence; 62% report that they work at least *once a week* with children who witness violence. Again, it is important to emphasize that these figures do not tell us about actual prevalence or incidence rates; instead, the question effectively captures providers' *perceptions* about the frequency with which they interact in their professional roles with children affected by violence.

Types of violence witnessed by children

Parent to child violence and violence between adults in the child's home were identified as the two primary types of violence witnessed by children. As one preschool worker from the Department of

Human Services emphasized, "My circumstances do not involve the extremes of shootings, and other such [events] that are in [the] news. We have the more subtle, but damaging issues from home, and our society's messages about violence as an acceptable way to solve problems." About two-thirds of providers also identified peer violence as one of the primary types of violence witnessed by children. Stranger or street related violence was ranked as the least likely type of violence for children to witness, as represented by the following graph:[32]

Providers' Perceptions:
Primary Types of Violence Children Witness



"Other" types of violence witnessed by children included: war in native country; violence at school; suicide in the home; elder violence; child to parent violence; and violence perpetrated by other relatives or caregivers.

These findings are consistent with data from the study which led to the inception of the Child Witness to Violence Project at Boston Medical Center [Please see Appendix F]. Last year, children who witnessed domestic violence represented 80% of referrals to the CWVP. Consistent with the

literature, these figures suggest that violence in the home is one of the primary types of violence witnessed by children.

Identification of children who witness violence

Early identification of children who witness violence ensures that children obtain access to appropriate services. The survey indicated three primary ways in which providers identify children who witness violence:

- 78% of providers report they are informed by another professional;
- 78% of providers report they observe emotional or behavioral characteristics in children about which they are concerned; and
- 77% of providers indicate that children disclose.

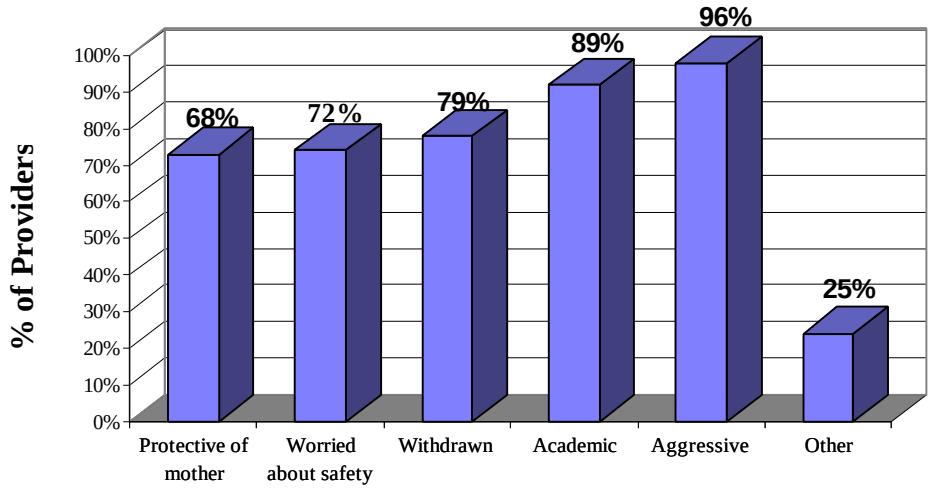
The surprising finding is that almost 80% of providers indicate that children disclose. Betsy Groves, Director of the Child Witness to Violence Project at Boston Medical Center, emphasizes the importance of "case finding" practices to identify children who witness violence precisely because children are *unlikely* to disclose. However, it is important to point out that providers included in this survey work with children up to age eighteen, where the CWVP only works with children eight and under; disclosure rates may vary significantly by age.[33] One of the important implications of this finding is that providers need to be trained to respond to children who disclose, especially for providers in non-clinical settings.

> ***I am concerned that I don't know enough about how to identify symptoms and therefore don't know which children are affected without verbal information.***
>
> **- Teacher, Cambridge Rindge and Latin High School**

Needs of children who witness violence

Consistent with the literature, providers indicated that children who witness violence exhibit a range of adverse behavioral, emotional, and academic outcomes. The following graph represents providers' perceptions about the primary behavioral and emotional characteristics displayed by children who witness violence:

Providers' Perceptions:
Behavioral or Emotional Problems Associated with Witnessing Violence



It is also important to note that one-quarter of providers identified "other" behavioral or emotional characteristics displayed by children who witness violence, as indicated below:

Providers Perceptions:
Other Problems Associated with Witnessing Violence

- Conduct disturbances: fires setting; stealing; violent play themes; cruelty to animals
- Sexually acting out
- Sleep problems: nightmares; insomnia
- Truancy
- Depression; low self esteem; suicidal
- Psychosomatic complaints
- Dating violence and substance abuse
- Agoraphobia
- Regressive behaviors: bedwetting
- Anxiety and panic
- PTSD
- Developmental delays

HOW DOES CAMBRIDGE COMPARE TO THE MODEL?

Survey findings provide a useful map for identifying "next steps" when held up against the best practices model detailed in the previous section:

Table IV: How Does Cambridge Compare to the Model?

COMPONENT OF MODEL COMMUNITY BASED PPROACH	HOW DOES CAMBRIDGE COMPARE TO THE MODEL?
Early Identification and Intervention	• Level and type of training vary widely by provider type. • Lack of departmental protocol for screening and responding to children who witness violence. • Cambridge Police data: underreporting of children at domestic violence calls.
Collaboration Between Departments and Agencies	• Low referral rates between departments and agencies. • Underutilization of shelter community.
Partnership with Child Protection Agency	• Differential reporting rates to DSS by provider type. • Significant provider concern about DSS involvement.
Integrated Services for Children and Families Affected by Violence	• Lack of therapeutic services for women and children.

The summary findings presented in this table will be explored more fully below, with supporting anecdotal information from provider interviews and focus groups.

Early Identification of Children Who Witness Violence

***Key Finding*:**

Only one-third of school personnel and child care workers report that they have had training related to working with children who witness violence, versus 63% of providers overall.

Level and type of training vary widely by provider type

Overall, 63% of providers indicated that they have had some training related to working with children who witness violence; however, the level and type of training varied widely among providers. Less than 25% of school personnel indicated they had received training related to children who witness violence.

> ***Many of us are working in an area we are unfamiliar with. Most teachers have little training in this area and, although they try to help, they are not always sure of what to do.***
>
> **- Staff person, Kennedy School**

Even for those providers who indicated they had received some training about this issue, it is not clear what *type* of training they actually received. Providers' open ended responses about previous training suggested that few providers had actually received specialized training related to this issue. The Domestic Violence Unit at DSS and the Child Witness to Violence Project at BMC both offer training opportunities targeted toward providers working with children who witness violence. However, few providers indicated that they had attended these trainings. Providers listed graduate training, in-services, specialized workshops and seminars, and clinical supervision as forums for related training. Several providers also listed training which they received through the Community Oriented Policing Services (COPS) grant, a DVFZ training initiative between the Cambridge police department and neighborhood health centers.

Overall, the majority of providers identified the importance of ensuring that *all* providers had some basic training around this issue. As one clinical social worker noted, "I believe strongly that all mental health clinicians should be well trained in working with trauma and domestic violence issues re: adults and children and sexual abuse of children. Specialized teams fall apart as funding is lost, and we are always back to square one. This should be a minimum competency requirement." Similarly, one pediatrician expressed concern about her own ability to identify children who "don't act out, spontaneously volunteer information, or respond to questions."

Lack of departmental protocol for screening and responding to children who witness violence

For clinicians, early identification requires clear protocol for screening and responding to children affected by violence. One focus group with the Outpatient Child and Adolescent Psychiatry Department at the Cambridge Health Alliance provided important insight into the importance of clarifying hospital based protocol around this issue. The hospital has a clear protocol for responding to

children who are themselves victims of physical or sexual abuse; however, no such protocol exists for responding to children who witness violence when the situation is not an acute one (i.e. an Emergency Room visit). As one provider emphasized, "We really don't have a clear standard of care." Noting the high prevalence of children exposed to violence in their caseloads, providers expressed uncertainty and concern about current responses and interventions. Although clinicians' assessments and evaluations of children include general questions related to domestic violence, screening tools do not include a specific level of detail around children's experience of witnessing violence.

Limitations of Cambridge Police Department data: underreporting of children at domestic calls

The lack of a clear and consistent protocol regarding police reporting of children at domestic violence calls severely limits the city's ability to assess the number of children who witness family violence.

Key Finding:

Police records from the period 1993-1995 indicate that children are reported present at *23%* of domestic violence calls:[34] a gross underestimate of the number of children actually present at domestic calls.

Based on her follow-up work with domestic violence cases, one of the Domestic Violence Unit's detectives estimated that children are involved in about *80%* of domestic violence calls.

This underreporting of children present during domestic violence, stems primarily from differences with which individual officers complete police incident reports at a domestic violence call. Incident report forms do *not* include standard questions related to the presence of children at a domestic violence call; instead, individual officers opt to include this information on the report form. Many officers do not record children as "witnesses" unless the child literally saw the incident and was specifically in the room at the time when the officer arrived [and not just in the house or apartment].[35] Although the Cambridge Police department has already provided four to five years of training to enhance the accuracy and consistency of police reporting, data about the number of children present at domestic calls has not consistently improved.

Domestic violence trainers state and nation wide have consistently stated that a major obstacle in enforcing accurate police report writing [for any crime] is the lack of thorough report reviewing by superior officers. While many departments do not have "report review officers" [including Cambridge], this should not prevent superior officers from thoroughly reviewing and correcting reports.[36]

Collaboration Between Departments and Agencies

Key Finding:

In responding to children who witness violence, only one-third of providers indicated that they make referrals to outside professionals.

Low referral rates between departments and agencies

Measuring the level of collaboration between departments and agencies in responding to children who witness violence is somewhat problematic. However, one way to assess interdepartmental or interagency collaboration is to consider the level and type of external referrals made by providers.[37] About one-third of survey respondents indicated that they referred children to professionals outside their own agencies or departments. It is difficult to discern whether this low referral rate has more to do with the lack of services for children affected by violence or with providers' lack of knowledge about existing resources. However, in a more integrated community network for children who witness violence, one would expect providers to have more contact with each other. As one social worker at The Guidance Center emphasized, "Collaboration work with different agencies is at times difficult as each agency has [an] agenda and political pressures."

Many providers who participated in the survey or in focus groups stressed the importance of improving communication and coordination between departments. As one nurse at the Cambridge Health Alliance indicated, collaboration ensures continuity of care and support for families: "In an arena of increasing violence I think it is difficult to keep up with violence trends and effects on various

cultures, etc. I feel it is important as an inpatient facility to increase in-services and contact with outside agencies to provide increased continuity of care and support for our patients and families."

Underutilization of shelter community

Survey respondents indicated that they had limited connections to the battered women's shelter community; only *one* provider indicated that she made referrals to local shelters. In a follow up interview about survey results with Sandy Middleton, Children's Services Coordinator at Transition House (a Cambridge based shelter for battered women), she emphasized that services and resources available at Transition House are underutilized by the community. She indicated that in her two years with the Children's Services Program at Transition House, only six teachers had contacted her for consultation related to a child; in addition, she had proactively reached out to three teachers who had children from Transition House in their classrooms. Highlighting the exceptional cases in which a teacher calls her for assistance, she stated, "It's the smart teacher who knows that they can call the shelter." She also emphasized that shelter staff can provide both consultation services and training for schools and hospitals about the impact of witnessing violence on children.

Partnership with DSS

***Key Finding*:**

Only one-third of teachers and child care providers contact DSS, compared to 68% of providers overall.

Differential reporting rates to DSS by provider type

As indicated above, departments lack clarified protocols about how providers should respond to children who witness violence; a significant amount of confusion stems from the fact that it is difficult to assess how a provider should respond to a child who is a witness to, but not a victim of, violence.

Similar issues were raised in relation to DSS involvement; in particular, guidelines for filing 51As with DSS for children exposed to violence remain unclear. Given that a significant number of children who witness violence are at risk for abuse, witnessing violence often represents a serious threat to a child's safety.

Differential reporting rates by provider type are also evident. Of those providers who report they have responded to children affected by violence, 38% of school personnel and child care workers indicated they refer to DSS, compared to 76% of health care providers and 64% of providers overall. Responses to open ended survey questions corroborate the finding that teachers are reluctant to file reports with DSS.

Significant provider concern about DSS involvement

Open ended survey responses, focus groups, and interviews indicated significant provider concern about the role of DSS involvement in responding to children who witness violence. In addition to questions related to filing, providers raised the following concerns:

- **High number of cases screened out by DSS:** Domestic Violence liaisons at area DSS offices have significantly improved the way in which DSS deals with domestic violence related cases. However, providers emphasized that a significant number of these cases continue to be screened out by DSS. Providers pointed out that it is the *intake* worker who determines whether cases are screened in; in effect, the entry point into the system represents a critical barrier for providers who seek DSS involvement.
- **Effectiveness of DSS involvement:** Providers questioned the effectiveness of DSS involvement with regard to ensuring the safety of children and the well being of families. Even when cases *are* screened in, providers emphasized that DSS often provides insufficient protection.
- **Supporting battered women *and* protecting children**: Several providers expressed concerns about the impact of filing on a battered woman's ability to address her family's needs. As a social worker from the Guidance Center emphasized, "It is always tricky to be in the role of therapist and to manage the care and protection issues that are necessary for the child's safety. We often have an

alliance with both the child and the parents which is absolutely necessary - and then when the child discloses and a 51A has to be filed, it can be tricky (but necessary)."

- **Prior difficulties with DSS:** Several providers stated that prior difficulties with DSS contributed to their hesitation about involving DSS in new cases. As one Special Education Teacher emphasized, "There isn't enough emphasis put on the fact that we are mandated reporters. People often have bad experiences with some of the DSS workers and are hesitant to get involved."

Betsy Groves emphasized that concerns about DSS involvement in responding to children who witness violence have also been identified at CWVP's regional conferences around the state. In addition, staff in the DSS Domestic Violence Unit indicated that a task force has been formed to address these issues at the state level; in particular, clarification and standardization of intake guidelines in domestic violence related cases have been identified as a serious concern.

Services for Children and Families Affected by Violence

> ***A serious concern is how to intervene effectively in the lives of children whose families are already terribly chaotic and disruptive. Individual therapy is often not adequate unless the family system is stable enough to support consistent therapy.***
>
> **- Psychiatrist, Cambridge Hospital**

The survey generated a wide range of open ended responses about the need for additional services for children who witness violence. In their open ended responses, only two providers specifically identified the need to establish a specialized and structured program for children who witness violence in Cambridge. As one psychologist from The Guidance Center emphasized, "As a community mental health center, my preference would be to have more specialized training for people here, rather than feeling a need to send families elsewhere, and then increase exposure to unfamiliar, possibly unsettling systems." However, in addition to the training needs identified above, providers highlighted the need to develop direct services in the following areas:

- **Support groups and services for children and parents:** The need for support groups for children and parents emerged as the primary recommendation in providers' open ended responses about the need for additional services for children who witness violence. Providers identified a range of programmatic options related to such support groups, including hospital, school, and community based services for children.
- **Services for immigrant families:** Providers expressed concerns about appropriate outreach to and intervention with children from different ethnic or racial backgrounds, particularly immigrant families. Providers identified the following areas of concern: linguistic barriers; different cultural definitions of violence; strong family loyalty patterns which may prevent children or women from disclosing that they have been victims of abuse; experiences of war related violence in native countries; and fear and isolation related to accessing services. As one social worker emphasized, "Children from non-English cultures are often more protective of a parent or more loyal; they often come with other domestic traumas but also traumas related to [their] immigration experience. They are less able to express their need for [help]or access help due to language barriers."
- **Family supports:** Providers emphasized the importance of working with children in the context of family based support services. In other words, effective intervention with children requires outreach to and support for battered women and their families. As one social worker from a neighborhood health center emphasized, "I think we need more support for families. One can not just treat the child. The whole family needs support and understanding." Several providers emphasized the importance of home based support programs, particularly for immigrant families. In particular, providers in focus groups and interviews focused on wider domestic violence related issues, including the importance of providing education, services, and legal advocacy for battered women.

RECOMMENDATIONS:
Building a Community Response to Children Who Witness Violence

In the beginning stages of this study, one of the possible policy options was to assist Cambridge to develop a strategic plan for a model clinical intervention for children who witness violence. However, research findings suggest that before Cambridge implements additional clinical interventions, several critical steps must be taken to ensure a more integrated and holistic response to this population. In particular, survey findings underline the need for interdisciplinary training and support for providers to improve early identification of and intervention with children who witness violence.

The following summarizes the key recommendations which have emerged from the research and preliminary work conducted. Using the "best practices" model for building a community response to children who witness violence, these recommendations are offered as a guide for the city's continued work.

Table V: Key Recommendations

BUILDING A COMMUNITY RESPONSE TO CHILDREN WHO WITNESS VIOLENCE: KEY RECOMMENDATIONS	
Early Identification and Intervention	• Implement DVFZ School Leadership Team training proposal for 1998-99. • Conduct an intensive, interdisciplinary training with the Child Witness to Violence Project for Cambridge providers. • Improve documentation of children's exposure to violence, specifically by the police, school, health, and human services departments.
Collaboration Between Departments and Agencies	• Enhance utilization of children's services programs at Transition House and Respond.
Partnership with Department of Social Services (DSS)	• Conduct in-service trainings between DSS and major city departments and agencies.
Services for Children and Families Affected by Violence	• Develop short-term working group to initiate further research, clarify need for additional therapeutic services, and pursue funding options.

A few of the recommendations are de-centralized. In other words, these are recommendations that departments and agencies can undertake directly with DSS, in collaboration with other agencies, or in-house. There are also several recommendations that require more formal collaboration. In addition to working with the existing hospital and school-based DVFZ task forces in the school, the DVFZ Core Group will facilitate time-limited working groups to develop the proposed collaborative recommendations.

The DVFZ initiative is an important foundation from which to build an integrated, community response to children who witness violence. The proposed recommendations are initial steps, not end outcomes or results. It is important that all interested parties (e.g. community based organizations; city departments) work with the DVFZ Core Group to assess the recommendations and begin short term implementation measures.

Early Identification and Intervention

Recommendation:
Implement DVFZ School Leadership Team training proposal for 1998-99.

- **Action step:** Submit final report to School Leadership Team meeting to ensure that that the training issues related to providers' role in responding to children who witness violence are incorporated into school-based trainings.
- **Action step:** Submit request to School Superintendent that Professional Development Points (PDPs) include issues of violence prevention, training on children who witness, and domestic violence awareness.

One of the primary goals of the DVFZ initiative is to develop and implement domestic violence trainings with all major city departments. The DVFZ initiative has already conducted two major training initiatives of city providers: a collaborative training between Cambridge Police and neighborhood health centers and a mandatory training of personnel in the Cambridge Housing Authority and the Cambridge Department of Human Services. Given the low level of teacher training identified in the provider

survey, the Cambridge Public Schools should be prioritized as the next major department to receive domestic violence training.

Findings from Provider Survey:
Training Issues for School Personnel

- Impact on Children of Witnessing Violence
- Identification of Children who Witness Violence
- Existing Resources and Services for Children
- Support for Teachers
- Filing 51As

The DVFZ initiative contributed to the formation of the DVFZ School Leadership Team, a working group within the School Department, in December 1997. Under the direction of Deputy Superintendent Pat Murphy and Director of Hooking Kids on School Steven Brion-Meisels, the Leadership Team was formed to strengthen the role of schools in responding to children affected by violence. The DVFZ School Leadership Team recently developed and submitted a draft recommendation for a year long plan to provide awareness training for all school department staff. The goal of this effort is to "increase institutional expertise within the schools and across the system in areas related to domestic violence prevention."

Recommendation:
Conduct an intensive, interdisciplinary training with the Child Witness to Violence Project for Cambridge providers.

The Violence Prevention Coordinator should convene a time-limited working group to develop and submit a request for technical assistance from CWVP to develop an interdisciplinary training module for Cambridge providers.

Since CWVP training modules include a maximum of 30 providers, the training should include a few key representatives from city departments, shelters, and community based agencies Representatives who attend the training would then serve as "in-house" expertise within their own departments and agencies. Once an interdisciplinary training has been conducted, further consideration needs to be given to what role these representatives could play in training other providers.

Goals of CWVP Interdisciplinary Training Module for Cambridge Providers

- Enhance providers' ability to identify and intervene with children who witness violence;
- Ensure "in-house" capacity and expertise on children who witness;
- Build relationships among providers who interact with the same children at different "entry" points in the system;
- Develop new leadership on domestic violence issues within city departments and agencies; and
- Remove barriers to collaboration.

Technical assistance is available through the current collaboration between the CWVP and the Attorney General's office, "Working Together for Children Who Witness Domestic Violence." This collaborative statewide initiative is scheduled to be implemented throughout 1998. Designed to raise awareness about the needs of children who witness violence, to support providers who work with these children, and to improve linkages within communities, the initiative consists of three primary components: 1) a series of nine one-day trainings throughout the state, 2) three two-day clinical

seminars for mental health providers and counselors, and 3) technical assistance for communities that seek to develop and implement a collaborative, integrated response to children who witness domestic violence. In a meeting on March 27, 1998, Groves expressed her enthusiasm and support for developing a training for Cambridge providers.

Recommendation:
Improve documentation of children's exposure to violence, specifically by the police, health, school, and human services departments.

- **Action step:** Utilize hospital based DVFZ Committee as a conduit to develop protocol for screening and responding to children who witness violence.
- **Action step**: Present findings from provider survey at a DVFZ committee meeting.

In its first year of operation, the DVFZ Committee at the hospital undertook several important initiatives, including: putting screening practices into place in the Department of Medicine; developing and implementing an overview of domestic violence at the new employee orientation; and surveying primary care providers about barriers to screening for domestic violence. For its second year, the committee has identified the need to examine staff training and screening in other departments and to assess existing resources for domestic violence related work (i.e. access to social workers). Survey findings provide an important background for the committee's continued work as they reflect the attitudes and concerns of providers within the Cambridge Health Alliance.

- **Action step:** Explore specific report writing and evidence gathering training options to enhance police officers' documentation of children present at domestic violence calls.

Improved police reporting of children present at domestic violence calls also provides a more accurate assessment of the number of children exposed to family violence and enhances police officers' response to and acknowledgment of children at the scenes of domestic calls. The Cambridge Police Department does not have a DVFZ committee, as in the school or the hospital. Instead, the Domestic Violence Unit serves as the primary conduit between law enforcement, city departments and the community.

The results of this study should be disseminated to the Police Commissioner to raise awareness about the importance of improving police reporting of children at the scene of domestic calls. In

addition, the Cambridge Police Department should explore specific report writing and evidence gathering training options to enhance police officers' response to children at domestic violence calls.[38] New Haven's Community Based Policing Project offers one potential training model which the Cambridge Police Department should consider. In addition, the department should be a part of a CWVP facilitated, interdisciplinary training to emphasize to patrol officers and their supervisors the importance of identifying the presence of *all* children at domestic violence calls.

Related Policy Update:
Pilot testing of new incident report form for domestic violence calls.

Currently, the Executive Office of Public Safety (EOPS) is exploring the implementation of a new incident report form for domestic violence related calls. Modified by the Committee on Uniform Enforcement, a subcommittee of the Governor's Commission on Domestic Violence, the incident report form is being piloted by numerous police departments in the state. The form utilizes check boxes in addition to a narrative section to document the presence of controlled substance abuse, threats, weapons, and the presence of children and other witnesses. If approved by EOPS, the form will be mandated in police departments across the state.

- **Action step:** If the new incident report form is adopted, the Cambridge Police Department, including the Domestic Violence Liaison, should ensure officers are trained on utilizing the new form.

Recommendation:
Enhance utilization of children's services programs at Transition House and Respond.

Representatives from the shelter community, including the Children's Services Coordinator at Transition House, should be central in collaborative efforts related to children who witness violence. Engaging appropriate shelter staff in the city's current efforts will improve collaboration with shelter and will strengthen providers' awareness of resources and services provided by Transition House and Respond. Interviews with shelter staff indicated support for and interest in the city's current efforts, particularly in relation to school based outreach.[39]

The DVFZ School Leadership Team should consider shelter staff as possible trainers for their upcoming proposal. Drawing on the expertise of Transition House and Respond represents an excellent opportunity to strengthen connections between shelters and municipal providers. For example, an outside trainer who provides a one day training would not develop ties to the school community. Instead, the benefits of a training offered by local shelter staff include the opportunity to build a sustained relationship between providers would recognize Transition House and Respond as a resource which they could consult about issues and questions related to children who witness violence.

Partnership with DSS

Recommendation:
Conduct in-service trainings between DSS and major city departments and agencies.

Effective collaboration with the Cambridge area DSS office is a critical next step in the city's planning process. Conducting in-service trainings between DSS and major city departments and agencies will provide a vehicle for addressing providers' concerns about both the effectiveness of DSS intervention and the screening of cases. In-service trainings should be utilized to clarify DSS's protective intake policy and screening protocol for Cambridge providers.

In addition, DSS should be included as partners in the city informal working group on children who witness violence. Engaging DSS at this stage in the process will put a "face" to DSS and will enable Cambridge providers to build better relationships with the area DSS office. Initial discussions with the DSS Domestic Violence Unit indicated significant support for involving DSS as a partner in Cambridge's continued work.[40] Area DSS Domestic Violence Liaisons are encouraged to participate in community round tables and other forums for collaborative work.

Recommendation:
Develop short-term working group to initiate further research, clarify need for additional therapeutic services, and pursue funding options.

Many of the recommendations generated by the provider survey rightly focused on wider domestic violence related issues and concerns. However, the development of additional services for children and families affected by violence is a long term goal. As initially identified in the DVFZ Implementation Report, it is estimated that new services could take up to five years to implement. It is beyond the scope of this PAE to outline a plan which ensures the provision of comprehensive, integrated services for children and families affected by domestic violence.

Instead, it is important to establish modest and achievable goals in the short term. The need for services will likely increase with improved identification of children and with increased interdisciplinary attention to the issue; as a result, the city must begin to prioritize the need for specific services to accommodate increased referrals. One area of consensus which emerged from the survey was the need for enhanced therapeutic support services for children, including both hospital and community based services. A smaller working group, which includes clinicians, school personnel, and shelter workers, should be convened to prioritize therapeutic options. As the city begins to assess and plan for the development of additional services, serious consideration should be given to ensure that services are culturally and linguistically appropriate.

CONCLUSION

The recommendations outlined in the previous section represent a range of short and long term options for the city to consider as it develops an integrated, community response to children who witness violence. In particular, key findings and recommendations have focused on the need for early identification of and intervention with children who witness violence. The School Department plays a critical role in this process; identifying children in schools *before* they are identified in crisis situations by hospital or police department staff will enhance early intervention and treatment. Research and practice indicate that teachers can play a primary role in identifying and responding to children who witness violence.

In order to represent a truly municipally based approach to children who witness violence, recommendations outlined here should also be integrated into city officials' emerging children's policy agenda: The Agenda for Children. Planning for the Agenda for Children began in September 1997; the goal of the Agenda is to bring together members of the community who are interested in children's issues and to establish priorities to guide the city's work over the next five years. The Agenda's Leadership Team includes the heads of three major city departments: the Superintendent of the Cambridge Public Schools; the Assistant City Manager for Human Service Programs, and the Chief Executive Officer of the Cambridge Health Alliance.

The Agenda for Children represents an excellent opportunity to build political and community support for developing an integrated, municipal model for responding to children who witness violence. The Agenda shares one of the major goals of the DVFZ initiative: to enhance collaboration between city departments and agencies in addressing the needs of children. In addition, discussions to date have identified violence prevention as one of six possible focus areas for the Agenda; meetings with community groups over the next few months have helped to refine and clarify these focus areas.

Recommendations related to the needs of children who witness violence should be incorporated into the final focus areas of the Agenda.

The majority of recommendations outlined in the previous section do not depend on new funding; however, developing additional services for children and families will require new funding. Given its unique approach to family violence, the DVFZ initiative represents an excellent opportunity to access upcoming funding opportunities. The DVFZ Core Group and/or a smaller working group should assess upcoming funding opportunities, including:

- ◊ **Governor's Commission on Domestic Violence:** The House Budget has recently approved a request for $700,000 to fund four child witness community pilot grants. This request for funding was submitted by the Subcommittee on Community Education for the Governor's Commission on Domestic Violence. If the budget is approved by the Senate, this proposal represents an exciting opportunity for Cambridge to apply for funds to develop an integrated community network for children exposed to violence. Funds from the grant can be used to help pilot communities address gaps in services and professional training, including counseling programs for mothers and their children or large scale provider trainings.
- ◊ **Department of Social Services:** DSS is also the primary funding source for community based programs and services for battered women and their children; approximately $10 million has been allocated to fund hot-lines, shelters, transitional living programs, counseling and support groups, advocacy services, and services for children who witness violence. Funding opportunities for children who witness violence may become available.
- ◊ **Collaboration between the Attorney General's Office and the Child Witness to Violence Project:** One of the goals of this year long collaboration is to develop new funding opportunities to enhance community based networks which serve children who witness violence.

In summary, Cambridge has the resources and potential to develop and implement an integrated model for responding to children who witness violence. With significant political support, the DVFZ initiative has provided a critical foundation for continued collaboration between city departments and community agencies. Efforts to strengthen current interventions and to develop new services must build on existing efforts and resources. It is also important for Cambridge to continue to work with other communities and programs in Massachusetts. The metropolitan region in particular is home to a wide range of innovative, collaborative initiatives in the field of family violence.

One of the most exciting possibilities about the work which Cambridge has undertaken is the city's potential to build a truly integrated, community response to children who witness violence. Ultimately, Cambridge may provide an effective model for other municipalities to adopt in developing their own local responses to children who witness violence. One of the primary lessons from the DVFZ initiative is that local government can and *should* play an important role in family violence prevention and intervention efforts. Combining the strengths of Cambridge's approach with the wisdom of other community based efforts will contribute to integrated, community networks which ensure the safety and well-being of all children and families.

Endnotes

[1] The following individuals provided a great deal of assistance with the development of the survey: Steven Brion-Meisels, Hooking Kids on School; Liz Dillon, Domestic Violence Liaison at the Cambridge Police Department; Sandy Middleton, Transition House; Nancy Ryan, Director of the Cambridge Women's Commission; Lynn Schoeff, Cambridge Health Department; Carol Sousa, Director of the COPS grant; Andrew Spooner, Department of Human Services, and Richard Wright, Violence Prevention Coordinator of the City of Cambridge.
[2] B. Groves, et. al. "Silent Victims: Children Who Witness Violence," *Journal of the American Medical Association* 269(2), (January 13, 1993), 262-264.
[3] J. Edleson, "Children's Experience of Domestic Violence," (St. Paul, Minnesota: University of Minnesota, May 6, 1997), Internet, 11pp; J. Kotch and V. Dufort, *Adverse Behavioral and Psychological Outcomes from Childhood Exposure to Violence*, (Paper presented at APHA Convention, November 1997).
[4] Studies cited in: Governor's Commission on Domestic Violence of the Commonwealth of Massachusetts, *The Children of Domestic Violence*, (April 1996), p. 13.
[5] *The Children of Domestic Violence*, p. 10.
[6] *The Children of Domestic Violence*, p. 13. For a complete list of cited studies, please see Footnote 9, p. 36 in the report.
[7] *The Children of Domestic Violence*, p. 15.
[8] *The Children of Domestic Violence*, p. 1.
[9] B. Groves, "The Child Witness to Violence Project," *Discharge Planning Update*, (March-April 1994), p. 15.
[10] *The Children of Domestic Violence*, pp. 14-15.
[11] M. Straus, R. Gelles, and S. Steinmetz, *Behind Closed Doors: Violence in the American Family* (New York: Anchor Press, 198), cited in Schechter and Mihaly, p. 13.
[12] G. Hotaling and D. Sugarman, "An Analysis of Risk Markers in Husband to Wife Violence: The Current State of Knowledge," *Violence and Victims*, 1(2), 1986, pp. 101-124, cited in Schechter and Mihaly, p. 13.
[13] *The Children of Domestic Violence*, p. 16.
[14] Cambridge Police Department, *Annual Crime Report 1996: Neighborhood and Business District Crime Profiles*, (Cambridge, MA: 1996).
[15] *The Children of Domestic Violence*, p. 40.
[16] The importance of building coordinated, community based systems to respond to domestic violence was also highlighted in Schechter and Mihaly.
[17] F. Farrow with The Executive Session on Child Protection, *Child Protection: Building Community Partnerships*, (Cambridge, MA: John F. Kennedy School of Government, Harvard University, 1997).
[18] Children's Safety Network, Adolescent Violence Prevention Resource Center, *Children as Witnesses to Violence: Programs/Resources*, (Newton, MA: Education Development Center, Inc.).; R. Weissbourd, *The Vulnerable Child: What Really Hurts America's Children and What We Can Do About It*, (Reading, MA: Addison-Wesley Publishing Company, 1996), pp. 217-222.
[19] Weissbourd, pp. 214-217.
[20] *The Children of Domestic Violence*, p. 19.
[21] *The Children of Domestic Violence*, p. 19.
[22] *The Children of Domestic Violence*, p. 21.

[23] F. Farrow with The Executive Session on Child Protection, *Child Protection: Building Community Partnerships*, pp. 16-17; *The Children of Domestic Violence.*
[24] *The Children of Domestic Violence,* p. 10; F. Farrow with The Executive Session on Child Protection, *Child Protection: Building Community Partnerships*, p. 23.
[25] DSS information; Schecter and Mihaly, p. 2.
[26] The project has targeted two additional communities as sites for the pilot. Each pilot will last seventeen months, with the second pilot scheduled to begin 6-8 months after site one and the third pilot scheduled to begin 14 months after the first pilot.
[27] N. Narain, *Project Safe Family*, Program Description (MCBWSG).
[28] F. Farrow with The Executive Session on Child Protection, *Child Protection: Building Community Partnerships*, p. 6.
[29] *The Children of Domestic Violence*, p. 28.
[30] F. Farrow with The Executive Session on Child Protection, *Child Protection: Building Community Partnerships*, p. 7.
[31] F. Farrow with The Executive Session on Child Protection, *Child Protection: Building Community Partnerships*, p. 7.
[32] It is interesting to note that 15% of providers identified "other" types of violence witnessed by children, including: war in native country; violence at school; suicide in the home; elder violence; child to parent violence, and violence between relatives or other caregivers.
[33] Of the survey respondents, 30% worked with children 0-3 years; 63% with children 4-6 years; 70% with children 7-12 years; and 81% with children 13-19 years.
[34] Cambridge Police Department, Summary of Operation Safe Home: Edward J. Byrne Memorial Grant Program, (Cambridge, MA: November 6, 1995), p. iii.
[35] Interview with Liz Dillon, Domestic Violence Liaision, Cambridge Police Department.
[36] Interview with Liz Dillon, Domestic Violence Liaision, Cambridge Police Department.
[37] It is instructive to note that only four providers indicated that they referred children to The Guidance Center, a community mental health agency for children and families. Two providers also indicated that they referred children to the Child Witness to Violence Project; however, both cited distance as a major obstacle for families. Including a question on the survey about providers' perceptions of each other may have been a useful way of exploring this issue in further detail.
[38] Interview with Liz Dillon, Domestic Violence Liaison, Cambridge Police Department.
[39] Interview with Sandy Middleton, Children's Services Coordinator, Transition House, April 5, 1998.
[40] Phone interview with Myra Rosenbaum, Policy Analyst, DSS Domestic Violence Unit, April 6, 1998.